ARIZONA BREAST HEALTH SPECIALISTS
at the Breast Center of Southern Arizona
A Partner of OneOncology

Patient's Contact List – HIPAA & Emergency Contacts

Legal Patient Name: _____ Date: _____

Patient Date of Birth: _____ MRN#: _____

You have the option to select different types of contacts. You can designate one person to be both a HIPAA and Emergency Contact, but you also can designate separate people as either a HIPAA Contact or Emergency Contact.

A HIPAA contact is a person who you authorize Arizona Breast Health Specialists (a division of Arizona Blood and Cancer Specialists, PLLC) to release information to about your medical condition. Any physicians who provide medical care to you don't need to be listed as HIPAA contacts.

It is important for you to name an Emergency Contact. This is a person that you authorize our staff to contact in the event you have a medical emergency while being treated in our office.

				Type of Contact:	
Contact Name:				☐ HIPAA	☐ Emergency
Phone Number:		Other Phone:			
Relationship:					

				Type of Contact:	
Contact Name:				☐ HIPAA	☐ Emergency
Phone Number:		Other Phone:			
Relationship:					

				Type of Contact:	
Contact Name:				☐ HIPAA	☐ Emergency
Phone Number:		Other Phone:			
Relationship:					

____ I understand that I am authorizing Arizona Breast Health Specialists (a division of Arizona Blood and Cancer Specialists, PLLC) to disclose my personal health information to the individual(s) named above whom I have identified as my HIPAA contact(s).

____ I acknowledge that I have received a copy of Arizona Breast Health Specialists (a division of Arizona Blood and Cancer Specialists, PLLC) Privacy Practices.

____ I acknowledge that I have the right to change contacts on this list at any time; that I can re-designate the Type of Contact originally stated; and that I have the right to revoke this contact list.

____ I acknowledge that any revocation of this list must be made in writing.

____ I have read this form, or had it read to me and I understand the consequences of my choices.

____ I understand that refusal to sign this authorization will not impact my ability to obtain care from Arizona Breast Health Specialists (a division of Arizona Blood and Cancer Specialists, PLLC)

Patient Signature: _____Date / Time _____ (select one) ☐ AM ☐ PM
(or authorized representative)

Physician: _____ Employee Initials: _____ *Rev. 07/2019KR*